

# THE CLINIQUE.

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VOL. XI.]

CHICAGO, MARCH 15, 1890.

[No. 3.]

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## Original Lectures.

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### *THERAPEUTICS OF ACUTE CARDITIS.*

A CLINICAL LECTURE BY A. K. CRAWFORD, M. D., ASSOCIATE PROFESSOR OF THEORY AND PRACTICE OF MEDICINE, DELIVERED IN THE HAHNEMANN MEDICAL COLLEGE, CHICAGO, FEBRUARY 26, 1890.

The first requisite in the treatment of acute heart disease is the isolation of the patient, together with the elimination of noises, it may be of light, and any and all disturbing influences, motion and emotion, society and anxiety from the sick room. These conditions must be observed and enforced if we are to derive any benefit from therapeutic measures. The surgeon insists upon quietude and rest for the one operated on, in order to obtain good union, whether of the soft or bony structure, and the physician must be equally insistent in cardiac inflammations, where so much depends upon the initial treatment of the disease.

As it is not alone the recovery from the acute attack that forms the ultimate object of the treatment, and as frequently the inflammatory process is latent from the first, and long-lasting, there are other means besides remedies, which demand consideration. Bathing must be conducted very carefully. It is seldom that a plunge bath is allowable at all, and a sudden cold plunge might be a fatal procedure. To

the majority cold water is decidedly uncomfortable, and cannot be applied without some degree of shock, yet it is desirable that patients of this class be brought to the point where they can bear cold ablutions. A splendid tonic effect upon the heart and general circulation is the effect when shock does not enter into its application.

We have it upon very good clinical authority that patients with heart disease can be inured to this form of treatment by giving them baths morning after morning, each repetition being with water of a lower temperature, and in a week's time find them perfectly tolerant of a cold bath.

The cold compress is likewise an aid sometimes employed over the cardiac area in cases attended with continuously violent and rapid action of the heart. It will usually reduce this excessive activity, only the time for reaction must be watched, and if the heart again becomes boisterous, another application must be made of the ice-bag or cloths wrung out of ice-water, keeping them on a shorter time than previously.

The only element in dressing worthy the physician's attention beyond the patient's comfort, is to note and guard against constrictions. Not only is this likely to be harmful in the event of a tight corset being worn, but it is bad, too, to have the chest, arms or legs compressed, so that corsets, belts and garters are very generally to be tabooed by subjects of heart disease. It is a notable fact that a large number of deaths occur among the British soldiery from heart affections, and not a little of this baneful state has been attributed to the snugly-fitting clothing and belting of their outfit.

Cardiac subjects are always easily chilled, and being so strongly mixed up with rheumatic complaints, it is advisable, when they are so situated that they can follow instructions, that they should move south during the winter months and return to the north in the summer. Nor is altitude in a southern residence an objectionable feature. If the rheumatic invalid can bear an elevation of 1,000 feet to 2,000 feet without inducing a return of his old enemy, the damaged heart will not be affected by the height. Therefore, a mod-

erate elevation, like that encountered in the resorts of the Cumberland hills, the Adirondacks or the Alleghanies, is perfectly allowable in heart cases.

The diet for these patients should be light in quantity but not in quality. That is to say, good, nourishing foods, and little fluid, should be the rule. The common, starchy commodities are of little use, besides requiring considerable water for their digestion.

But all kinds of meat are allowable, and should invariably be accompanied by a portion of some green vegetable. The order of eating should be a light breakfast of sustaining food, a liberal dinner at mid-day, and again in the evening, a small supper, warning the patient never to go to bed with a full stomach, for pressure upon the heart of gaseous distension is more than likely to cause palpitation and præcordial distress.

There are two forms of alimentation somewhat in vogue in certain districts of Europe, domestically, for the eradication of heart disease, which go by the names of the "whey cure," and the "grape cure." Whey curds are given as food, to the exclusion of all other diet, and the patients are given baths of the same. As curds are not the most easily digested article in the world, alkaline mineral waters are advised to be taken with them, especially at first, until the stomach shows its ability to digest the mass without trouble. The effect of this mode of treatment is said to be to reduce the rapidity of the pulse, to make the bowels lax, and to limit secondary congestions. The results accruing from the ingestion of large quantities of grapes are set down as being very similar to those witnessed in the whey cure, with the additions of more free diaphoresis and urination. Some food is usually prescribed with the grape diet, in which case the grapes are eaten half an hour before each meal, to the extent of one, two, or even three pounds at a sitting. Or, in the event of a patient living near by a winery, the grape juice is drunk as it comes from the press.

Having had no experience with these odd plans of treatment I cannot add or subtract aught from their claims.

The remedies in use for the acute inflammations of the heart are numerous, and for a very good reason. The carditides invariably spring from some other disease, and when we think of the variety of these sources of origin, such as pyæmia, puerperal fever and Bright's disease, injuries to the chest, over-exertion, and neighboring pleural inflammation, as well as the exanthemata and articular rheumatism, there no longer remains a wonder in the mind why so many drugs should be listed under this head. Keeping these several etiological factors in mind will often aid the physician in his choice of the best remedy for his case in hand.

For acute carditis, whether it is peri-, endo- or myocarditis, aconite stands as the first and foremost remedy. It is, inversely, as important a remedial agent in acute cardiac disease, as it is unimportant in croupous pneumonia. Its pathogenetic effect upon the heart is to set up pericardial inflammation or to develop the endocardial changes which give rise to murmurs at the mitral or aortic orifices. It is, therefore, of use in the primary stage when attended with febrile movement, and also when the local mischief is still progressing after the subsidence of the constitutional disturbance. It is, preëminently, a sthenic form of the disease which calls for aconite. This state is easily determined when the fever is marked by an elevated temperature, a full, bounding pulse, dry skin, restlessness, and anxiety of mind. But when several of these elements have been wiped out a sthenic form of inflammation may still be in progress, and the guiding symptom will then be found in the maintenance of the equilibrium of the circulation. The heart and pulse will be fairly synchronous with each other, and those secondary effects of an overtaxed organ, such as venous engorgement and congestions, will be long in making their appearance. Under these circumstances benefit will be derived from the continuance of aconite for a period of several months. In this affection the much-thought-of and much-talked-of aconite, as a remedy useful only in the onset of the acute diseases, must be

considered in the light of a beneficial agent for both the sub-acute and chronic conditions.

We might almost say of digitalis that it stands as the antonym of aconite in acute carditis. The lesion under this drug progresses in the most insidious way. It is a latent inflammation from the first and very early develops signs of asthenia. There is marked embarrassment of the respiration, with a weakened peripheral circulation. The face becomes puffy and of a bluish hue, and although the countenance is anxious, as is usual in heart disease, there is none of the restlessness observed under aconite; but instead, a passivity and disinclination to move. The engorgement of lung tissue often gives rise to bloody sputum, not at all like the *rusty* sputum of pneumonia. A sphygmogram will show developing dicotism long before it can be detected by the finger, and on this evidence alone I have demonstrated in the hospital the efficacy of digitatis, in a dilution, a few days sufficing to eradicate all traces of the capillary and cardiac atony.

In pericarditis digitalis is indicated when the friction murmur soon disappears, in consequence of an early and copious serous effusion. The action of this remedy here is witnessed chiefly upon the renal function. The tone being restored to the circulation, the kidneys secrete abundant urine, and the effusion in the pericardial sac becomes absorbed.

By analogy bryonia should be a good remedy in cardiac inflammation, because it affects serous surfaces so readily; witness its action in pleuritis and in inflammations of the joints, with their attendant serous effusions. Nevertheless it is a poor heart remedy, and had better be employed only as an intercurrent when complications are present. If the patient should suffer a relapse into articular rheumatism during the course of a heart affection, or, if the heart malady is consequent upon, or complicated with a pleurisy, or pleuro-pneumonia, then bryonia may be of value until such extraneous troubles are disposed of, but not beyond that.

In spigelia we find an excellent cardiac remedy with clear-cut indications. Carroll Dunham says of it: "It comes

after aconite; competes with bryonia; precedes spongia and lachesis, arsenicum and lithium." It is valuable in rheumatic endocarditis and pericarditis. It is always attended by characteristic pains, violent and stitch-like, and nearly always left-sided. In the left-sided facial neuralgia of this drug the fifth cranial is the nerve involved, but in cardiac disease the pains under the clavicle and at the xiphoid cartilage show how deeply the phrenics are implicated, and the dull stitches synchronous with the pulse point to the involvement of the root of the aorta. The stitch-like pains are so severe and so persistent as to arrest respiration and to cause extreme alarm to the patient. Attendant upon these symptoms, will be observed violent pulsation of the heart, and a marked aggravation of both the pain and heart's action when the patient attempts certain movements. A heavy, pressing, painful load is also felt in the præcordia, giving rise to a sense of constriction and anxiety. With such symptoms before you the spigelia may be prescribed with a well-grounded confidence in being able to relieve them.

That rheumatism plays a very principal role in the production of organic heart disease was indelibly stamped on my mind early in my medical career, through my proclivity to visit hospitals at any time and anywhere I might be. In going through a ward devoted to rheumatic subjects the house-physician drew my attention to case after case presenting cardiac murmurs. So you will require to be constantly on the alert for this complication, and be ready to meet it, and to advise the proper course to be pursued subsequent to the relief from the joint and muscular disability of such unfortunates. When still under the influence of the acute malady the family of gouty and rheumatic remedies will be the proper one from which to choose a medication to conquer the initial trouble. The chief of these remedies are Aconite, Bryonia and Rhus; Colcicum, Ledum and Rhododendron; Kalmia and Spigelia. Some of these are like the Bryonia, in that they have no specific action upon the structure of the heart, but they each have

their defined symptoms, and, when properly chosen, will dissipate the abnormal condition of the blood which perpetuates the rheumatoid state, and plays the mischief with the heart. Such a remedy as *rhus* is too well known and too well verified in rheumatism to require comment. Its action, likewise, in typhoid fever, as well as typhoid conditions in sthenic fevers—scarlatina for instance—makes it a prime drug in many instances where heart lesions are prone to develop. But having accomplished the relief from these characteristic symptoms, by its use, I can not conceive of its being of further benefit in carditis and its sequelæ.

When the point is reached where the heart disease is the chief, or possibly the only morbid state remaining, the lesion is beyond the reach of *rhus*, the time for its usefulness has gone by, and we must look elsewhere for remedial aid. *Colchicum* extends its action a little beyond *rhus* in relation to the heart, for hydro-pericardium is a state sometimes witnessed in its accidental poisonous provings. Yet this condition is but an example of its tendency to dropsies. Therefore its application must be to a limited number only of pericardial cases, marked by concurrent dropsical conditions, profuse sour sweating, paresis of the extremities, in a gouty or latent rheumatic subject.

Only one other remedy in this group will be specialized to-day, and that one is *kalmia latifolia*. It somewhat resembles *colchicum* and *rhus* in rheumatism, and like *rhododendron* and *ledum*, it is excellent for reducing a rapid pulse. But more than all these remedies combined, it acts beneficially upon the rheumatic heart, oftentimes to a marvelous degree. Its provings do not show it to be a superior cardiac remedy, but its clinical use has proven its efficacy in this regard. It has completely outstripped its pathogenesis, and we regard it as one of our most valued remedies in organic heart disease. In 1843 Dr. Hering conjectured that *kalmia* would be an important remedy in heart diseases alternating with rheumatism, and nine years after when Dr. Okie cured two cases of

organic disease following upon acute rheumatism, the original prover was greatly elated over his happy guess. Many of you have seen this remedy prescribed in our hospital, and I can assure you I have witnessed cures there in consequence of its use. The kalmia patient has no tenderness nor swelling of the joints. His rheumatism seems to be of a muscular character, and is attended with severe pains, and great lassitude of the limbs—especially the lower. These pains, too, have a characteristic way of involving a whole limb, from the hip to the heel, or from the shoulder to the fingers, and move quickly throughout the parts so affected.

The cactus grand. comes into play for certain of the heart cases which the kalmia seems just to miss. Those valvular affections arising from articular rheumatism, where, in the acute stages, rhus and colchicum had been thought of, and possibly prescribed, this remedy finds a particularly hopeful sphere for action. The subject may be of a gouty diathesis. Like the kalmia, the heart's action is rapid and liable to severe palpitations. But from what I have seen of these cases I should judge that the cactus heart was the more constantly boisterous of the two, being found in a more nervously excitable individual. The heart's action is so intense in such patients that the whole præcardial surface heaves with the pulsations, and he frequently complains of the sensation of an "iron band around the heart." It seems to me that Jousset condemns his own practice of administering cactus in the tincture, when he tells how, time after time, the drug in this strength aggravates the symptoms. In my use of it in the 3x or 6x dilution no such trouble has appeared, to be contended with. And there stands in the hospital records a perfect cure of a case in which cactus and china were the remedies used, both in potencies.

It was during the winter in which the clinics were being held in the college building, on account of the hospital having been burned down, that this man came for treatment for Graves' disease. The three hypertrophies of

this complaint were only too easily demonstrated in this case. The bulging eyes, the enlarged thyroid, and the hypertrophied heart were evident to every student who saw him in the sub-class room. And a loud blowing intra-cardiac murmur gave evidence of the deranged mechanism of the circulatory organ. His liver was greatly enlarged, and his skin was somewhat jaundiced and greasy to sight and touch. Unpromising as the case appeared, with that never-ceasing and rapid pounding of the heart, and visceral congestions, the patient went on improving steadily under the two remedies mentioned, until the skin had assumed a healthy condition and hue, the liver retracted, the irritability of the heart ceased, the hypertrophy disappeared, and with it all signs of a valvular incompetence:

I had hoped to have taken you further in the outline of cardiac therapeutics to-day, but the hour is up, and some of the most important of the measures and remedies for carditis have not yet been touched upon, therefore they must be left for another day.

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FINAL EXAMINATION IN THEORY AND PRACTICE, AND MEDICAL JURISPRUDENCE, IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO. Session of 1889-90.

1. Give the symptoms and treatment of cerebral meningitis.
2. What are the symptoms of epilepsy and its differential diagnosis?
3. What are the pathognomic symptoms of diabetes?
4. Give the diagnosis between ulcer of the stomach and gastralgia, and the treatment of the former.
5. What are the diagnostic symptoms and the treatment of pericarditis?
6. What are the diagnostic points between scarlet fever and measles?
7. Define the subcrepitant rale, its differential character from the crepitant rale, and at least those pathological conditions of the lung in which it is present.
8. Describe the lesions of capillary bronchitis and the symptoms they are bound to produce.
9. Give the hydrostatic test of the lungs of a dead infant, and the interpretation of it.
10. What are the five sources of evidence open to the medical jurist in cases of poisoning?

*ON DIABETES MELLITUS.*

THREE LECTURES DELIVERED IN THE HAHNEMANN MEDICAL COLLEGE AND HOSPITAL OF CHICAGO, BY C. E. LANING, M. D., PROFESSOR OF THEORY AND PRACTICE, AND OF CLINICAL MEDICINE.

## LECTURE II.

The symptoms of diabetes may be presented in more or less of a tabulated form, after the style of the text-books, but I prefer to give them to you in the order and manner in which they will appear to you in actual practice. There is no one symptom which can invariably be given as representing the *first* one, for different ones appear in different cases, and the same one in varying order in each individual patient. It is necessary to understand that certain symptoms which do not necessarily enter into the diabetic complexus are nevertheless often indicative of its onset, and should always be regarded with suspicion. These symptoms, representing the skirmish line of the main army, vary according to the train of causes at work to develop this disease. I will first give you the group of symptoms that are pathognomonic of diabetes. Remember that I said *group*, for no one symptom is pathognomonic of this disease.

If you find in a given case the following four symptoms, you may be positive that you have to deal with diabetes. They are polyuria, glycosuria, dipsuria and bulimia—especially for meat. If added to these you have emaciation, marked and progressive, the disease is in the second stage, and will require your best efforts to overcome it. There are many other symptoms that make their appearance during the onset and progress of the disease, and which, while they are not pathognomonic, are more or less characteristic. Dryness of the skin is usually quite a prominent symptom, and may be looked upon as one of those symptoms to which it is hard to give the proper significance, it being a question whether they are to be regarded in the light of cause or effect. In this instance the symptom mentioned has a dual significance, it undoubtedly being present as a

result of certain other diabetic symptoms, yet in turn giving rise to, or at least aggravating others. Thus it is a well-known fact that the ability of the blood to hold in solution and to oxidize sugar, depends to a great extent upon its alkalinity. The perspiration carries off a large amount of acid from the waste tissues, and when the skin becomes less active than normal, the blood current is burdened with much or all of the acid that should have been thrown out by way of the sudoriferous glands, and hence the alkalinity of the blood is lowered to a corresponding degree. In observing a case of diabetes it will generally be noted that the amount of sugar contained in the urine will vary as the skin is dry or moist. The specific gravity of the urine cannot be relied upon as an index of the quantity of sugar in such cases, as there will naturally be a greater amount of solids in the urine when the skin is inactive than when the glands are secreting freely, but a careful quantitative analysis will demonstrate the truth of the above statement.

Partly due to the presence of certain acids resulting from the decomposition of the saccharine elements in the blood, and partly to central nervous irritation, there is often developed intense itching of the skin, sometimes only that covering the trunk, but frequently the entire integument is affected by this most annoying symptom. While as a rule it does not appear until the disease is fairly developed, pruritus of the genital organs, particularly the labia of the female, and the scrotum of the male is often the first symptom to attract the attention of the observing physician, and to arouse his suspicions of a latent or incipient diabetes. A very persistent eczematous eruption often appears in the regions referred to, and should always suggest an analysis of the urine. It is generally considered due to the irritation resulting from saccharine urine, but while this may partly account for the symptom, there can be no doubt that some central trophic lesion has an important bearing on the subject. These symptoms are especially incident to women at the change of life.

Eruptions on various parts of the body often precede or complicate diabetes, and a number of succeeding crops of small boils should always arouse suspicion, and even if no other symptoms make their appearance for some time, it is wise to keep such a patient under surveillance. These boils have been thought to be due to the excess of saccharine matter circulating in the blood, but that this is the sole or even the principal cause I very much doubt, for it is so often the case that they precede all other evidences of diabetes by a number of months, and appear when there is no reason to believe that there is any excess of saccharine matter in the blood or other tissues of the body. It is simply an evidence of that trophic nerve-storm which is to destroy the organism later on, unless some powerful means be used to check it.

In some instances a concomitant symptom or forerunner of diabetes is severe toothache, or facial neuralgia. This is generally due to a more or less developed alveolar periostitis of the maxillary bones\*. This has also been attributed to the vitiated buccal secretions occurring in diabetes, but I think it is more likely due to a deeper cause, the nerve centres themselves, which gave rise to the changed secretions. If a patient who has been subjected to a great and violent grief, or who has had an almost constant mental strain of any nature, complains of a dull, heavy, disagreeable feeling in the back of the head, or of stinging pains in the back of the head, neck and spine, inquire of and watch the urinary symptoms. Such a patient gives promise of developing a case of diabetes. Any person subject to severe nervous strain who observes that the frequency and the quantity of the urine is increased at such times, requires watching; and when the polyuria manifests itself at night as well as during the day, it acquires additional significance.

Dryness of the mouth and lips with more or less thirst, is often one of the first symptoms noticed of diabetes, as

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\* For a remarkable case of this kind reported to the Clinical Society of Hahnemann Hospital by Prof. Ludlam, see the CLINIQUE, Vol. III, p. 184.

well as one which may persist all through the disease. The mucous membranes partaking of the dryness of the skin already referred to would naturally lead one to expect constipation, and as a rule it is present. Occasionally the renal secretion will be greatly diminished for a time, and the intestinal mucous membrane seemingly acts vicariously for the kidneys, and as a consequence for the time being the stools are frequent and loose.

Occasionally there is marked dysuria, the mucous membranes of the bladder being in a very irritable state. Sometimes a purulent cystitis is developed which more or less hastens the decline of the patient.

As I have before stated, the first symptom or symptoms observed in various cases differ greatly. Sometimes saccharine urine may be present for quite a while before any other suspicious or characteristic symptom is noted, and this fact is often first detected by flies and bees being attracted to the urine, or by its leaving a white, syrupy spot on the clothing, or on the floor where a few drops may have been deposited.

A failing of the eyesight occurs in some cases, varying according to the stage of the disease. It is generally caused by cataract but whether this is due to the mere fact that sugar is present in the fluids of the eye, cannot yet be definitely determined. It is, however, true that a certain amount of sugar injected into the orbital circulation will produce cataract, as carefully conducted experiments have amply demonstrated,

I wish now to say a few words in regard to the effect which certain articles of diet have upon the course of this disease. There is another way to look at the subject besides that which I shall present, still I believe the real effect that diet has is not generally or properly understood. It is well-known that if all saccharine or starchy food be withheld from diabetic patients, the quantity of sugar eliminated is greatly diminished, or may disappear entirely. At the same time the patient is usually much improved in other respects. This goes to prove that the portions of the

economy that have to do with the formation, storing up and assimilation of sugar, are so deranged that the introduction of the article acts upon them as an irritant, producing symptoms in an analogous way to that in which indigestible food does in the gastro-intestinal tract. Certainly the mere fact that sugar is eliminated by the kidneys does not cause the train of symptoms that usually accompany this condition; indeed, it is only a symptom itself, and the fact that it does not appear in the urine shows that the mechanism which has to do with its distribution and destruction, or rather conversion into other elements, is at fault.

If undigested food appears in the stools, we do not look upon that as ought but a symptom of gastro-intestinal disease, and we ascertain to what class of foods the undigested, unassimilated excrement belongs, and then we know whether the lesion is purely gastric, hepatic, pancreatic or intestinal, or if it is one that involves two or more of the organs named. In such a case if it be a lesion that is difficult of removal, we should commence by cutting off the supply of special food, which on account of the present diseased condition, is indigestible and consequently a source of irritation, not only to the organs whose function it is to digest it, but also to certain tissues with which it comes in contact as improper food, and which are not normally subject to such a source of irritation. In this way it gives rise to many reflex phenomena not connected with the primary disease, but only to the extent already shown, and these reflexes which for a time are entirely dependent upon the presence of this foreign substance, *i. e.*, the undigested food, may become more permanent in character and completely divorced from all connection with the original lesion, and continuing its disappearance, for the reason that the structures secondarily involved have finally become affected by an independent lesion.

Even though the food which is indigestible be withheld, and consequently ceases to appear in that form in the stools, it is no evidence that the pancreatic, hepatic, gas-

tric or intestinal lesion, as the case may be, has been cured or changed in the least. By this means, however, it is prevented from showing itself to a certain extent, and through the functional rest which the diseased organ has thus obtained, in addition to the assistance afforded by the appropriate remedies, a cure may result.

Making an application of these facts to the disease under discussion, I am led to believe that the articles of food containing sugar, or elements that are easily convertible into it, exert an injurious effect upon the various portions of the organism. The kidneys having to throw off this excess in addition to their other duties, ultimately become involved. Why should the great thirst and emaciation occur? It is simply because the sugar that is so necessary to cell life and growth is carried off by the urine. May not the thirst at the same time be due to the fact that an excessive quantity of urine is secreted?

We can hardly look upon these conditions as the cause of the symptoms named, for there is certainly enough sugar passing through the systemic circulation to afford nourishment to the various tissues, and enough water could easily be drunk to make up for the extra loss through the urine. Must we not then come to the conclusion that the disease is largely trophic in character, and that the various cells *cannot* take up the sugar and water which the blood offers them in abundance? If they did, the sugar and water could not pass off so rapidly by way of the kidneys.

If the primary lesion is in the fourth ventricle and has caused the diabetes in the manner already described, secondary lesions of the liver and kidneys would sooner or later appear. The cause of these latter troubles is more or less obvious, since the derangement of the circulation throughout the chylipoietic viscera tends not only to interfere with the function of the liver, but also with that of all the organs belonging to this group. On the other hand the burden that is thrown upon the kidneys certainly has a powerful tendency to derange the secreting functions of those organs.

We cannot go back of the fact, however, that the mere presence of sugar in the blood seems to act as an irritant to the structures affected in diabetes. Thus, in some cases much improvement is to be observed if all vegetable diet be withheld from the patient; the sugar that is formed out of the peptones, apparently not exerting the same irritating influence upon the diseased tissues as that which is formed from vegetables. Again the reverse is true. And this has led to dividing the disease into two forms, the mild and the severe. However, there is much evidence to show that these two forms are merely different stages of the same disease.

There are many points relative to this affection which require careful investigation. Thus, is the absence of the perspiration and saliva, which is a frequent symptom, due to the fact that so much water is thrown off by the kidneys in the urine, that nature tires and thereby diminishes the secretions referred to, in order to maintain the normal amount of water in the blood? However this may be, the great diminution of the perspiration has an effect upon the disease that has not previously been considered. Therapeutic agents, such as jaborandi, etc., produce copious transpiration, relieve the symptoms and lessen the quantity of sugar discharged by way of the urine. Of course this does not cure the malady, but it is a fact of the right kind and one that we may be able to utilize, for it will at least assist in throwing some light upon the true nature of this singular and fatal disease.

It can be readily seen that a variety of distinct and different lesions may cause such a derangement of the glyco-genic function of the liver as will result in diabetes. Thus various lesions of the brain may do so, by primarily deranging the circulation of the liver, as has already been shown. Again, there may be an inherent lack of power in the cells whose duty it is to convert the glucose into glycogen, while on the other hand those cells whose function it is to change the glycogen back to glucose may be excessively active either as a result of some local lesion, or of

one which is central, and which stimulates them to undue activity through the nerve fibres that serve as a means of communication. But, whatever the nature of the lesions that cause an excess of sugar to be thrown into the blood, or wherever they are located, they do not constitute the greatest danger to the organism. They are, I believe, to be found somewhere in the trophic nerve cells, where they give rise to serious symptoms because of the inability of the various tissues to take up the amount of sugar necessary to their proper development.

Sugar may be made to disappear from the urine either by restriction of the patient to a certain diet, or by the use of remedies. By withholding sugar, or sugar-making foods, the result is largely the same, or at least is obtained in an analogous manner to that of supplanting a diet of milk with one of cream in cases in which caseine is indigestible, and it cures or contributes to the cure of diabetes in the same manner. Some remedies increase the oxydizing power of the red corpuscles which is known to be below normal in diabetes as a rule, thus causing a greater consumption of sugar, a larger amount being converted into  $C O_2$  and  $H_2 O$ . In case of cerebral lesions affecting the liver as has been stated, some remedies may cause such a restoration of the flow and lessening of the lumen of the vessels of the portal system, as to remove one of the effects of the cerebral lesion, yet in either case would the medicine be curative. It could be shown how other remedies may remove some of the effects, and at the same time one of the most prominent symptoms of diabetes, without curing it, without removing the cause; but I trust enough has been said to demonstrate that such is true. Let me cite a case or two which will at once show how diversified are the causes of diabetes, and at the same time demonstrate the importance of ascertaining the lesion upon which it is dependent, and also, that sometimes at least, the attempt to prescribe according to the "totality of the symptoms" would not only be futile, but impossible. Imlach (*British Medical Journal*, July 11, 1885,) reports a case of pyo-salpinx, that was

complicated with diabetes. Nine days after the removal of the ovary and the tube the diabetes permanently disappeared.

Why may not this explain, to some extent at least, the peculiar tendency that women have to diabetes, during or following the climacteric? The case just cited certainly shows that a given amount of irritation in the reproductive apparatus may give rise to diabetes. At the special time of life referred to there is a great tendency for hyperplastic or atrophic changes to take place in the female generative intestine, and why may not some of them give rise in a reflex way to the complexus, as well as pus in the Fallopian tube? The withdrawal of vascular and nutritive forces from the sexual organs is prone, as is well known, to produce general or localized vaso-motor storms. It surely need not be a matter for surprise if the irritation resulting from the frequent and sudden vascular changes should affect, directly or reflexly, some of the centres that are concerned in the production of diabetes.

"Brunton cites an interesting case of diabetes consequent upon the presence of the tape-worm, which was cured by the removal of the worm. The peripheral irritation of the sensory sympathetic fibres may have been conveyed to the diabetic centre in the medulla, and reflected to the vaso-motor system of the liver. He thinks that the increased appetite caused by the presence of the worm may also have been instrumental in starting the glycosuria from over-eating."

This, as well as the case reported by Imlach, illustrates the necessity of removing the initial lesion upon which the various symptoms depend, and also demonstrates that, in order to remove it, the nature and location of the lesion must first be determined. The diabetes must have been due to the pyo-salpinx, for it ceased as soon as the diseased tube had been removed. Is it not clear that, if there be pus in the Fallopian tube or in the brain, the reflex symptoms will differ widely in each case? Will they not differ largely according to the special region of the brain which

may be involved? Is it reasonable, rational or scientific to presume or to claim that a collection of pus in the inferior, portion of the third frontal convolution requires a remedy for its removal entirely different from the one which would be curative if the pus was in the ascending frontal or the gyrus angularis? Would the *mere variation in the location of the pus call for a different remedy?* If not, then what of the "totality of the symptoms," for certainly they would vary greatly in each case, and no remedy in the materia medica does or can cover them all.

If a remedy had been sought for in the case of pyosalpinx and diabetes, it is clear that it need not have been one which contained any symptoms of diabetes in its pathogenesis. Indeed it would be only a fortuitous circumstance if it did, since the diabetic symptoms were purely secondary and reflex in character; and while the nature of the lesion giving rise to them, *i.e.* the inflammatory degeneration, might have been removed by a certain remedy equally well from the liver or the Fallopian tube, still that remedy need never have produced any symptoms of diabetes nor a host of other reflex symptoms that it might be capable of dispersing.

Is it not clear then, that if the pathological basis of the whole difficulty were recognized, *viz.* the pus in the tube, or the worm in the intestine, the chances for curing the the patient would be far greater than if symptomatology alone were relied upon? There is only *one* correct, scientific method of prescribing, and that is to take note of *all* the symptoms in the case, and then attach to each individual symptom, or group of symptoms, their proper significance. Thus, in almost all cases there are symptoms which indicate the site of the lesion, or others which indicate the nature of the lesion, and still a third group that serve to indicate the curative remedy. But we shall speak of the therapeutics of diabetes in our next lecture.

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## Clinical Society Transactions.

H. N. LYON, M. D., SECRETARY.

FEBRUARY MEETING, 1890.

At the February meeting of the Clinical Society, held at the Grand Pacific Hotel on the evening of Saturday, the 22d, the report of the Bureau of Nervous Diseases, due at this time, was substituted by a paper on

NASAL STENOSIS AND ITS SURGICAL TREATMENT.—By W. A. DUNN, M. D.—Nasal stenosis is usually understood to be any obstruction to the passage of air through the nose. It is therefore due to any affection of the nasal, naso-pharyngeal or pharyngeal cavities by which they become occluded. The intra-nasal occlusions are due to diseases affecting the turbinated bodies, changes affecting the septum, those affecting both the inner and outer walls of the nasal cavities, new growths and foreign bodies. The naso-pharyngeal conditions are due to adenoid vegetations, mucous and fibrous polypi, and adhesion of the soft palate to the posterior pharyngeal wall. Pharyngeal occlusion is the result of inflammation or hypertrophy of the tonsils. Changes affecting the turbinated bodies are due to congestion of the same, hypertrophy of the turbinated bodies and enlargement of the turbinated bones. Those affecting the septum are deflections, dislocation of the septum from the superior maxillary, bony projections of the septum, enchondromata and occasionally abscess and hamatomata. Congenital occlusion and membranous bands affect both walls of the nasal cavity. Among the new growths mucous, hypertrophic and fibrous polypi are the most frequently observed, but cysts, osteoma, exostosis and other forms are sometimes met with. Foreign bodies may consist of animate or inanimate objects or rhinoliths. The most immediate effect to be observed in nasal stenosis is oral breathing, in

consequence of which the cold and impure air passing directly into the larynx results in irritation of the pharyngeal and bronchial mucous membrane. The respiration is noisy, difficult and irregular, especially during sleep, when the patient often fights for breath and awakens unrefreshed.

In infants nasal stenosis may cause serious results on account of the child's inability to nurse as well as to sleep. The facial expression of mouth-breathers is characteristic, and especially if occurring during childhood. The nose is pinched and thin transversely, the alæ are undeveloped and lie flat against the septum. The eyelids are drooping, while the mouth stands agape. In fact, the expression is often that of idiocy. The hearing is frequently impaired on account of an extension of the inflammation into the Eustachian tube, or from improper ventilation of the middle ear.

The effect of nasal stenosis on the voice depends upon the location of the obstruction, and may be from the altered resonance due to closure of the anterior nares, to the complete deadness of speech resulting from obstruction of the naso-pharyngeal space. The singing voice is usually impaired in the upper register. According to Cooper, of London, stammering may result from adenoid vegetations; olfaction may suffer as the result of perfect occlusion of the nasal cavities or from growths in the superior nasal region, causing pressure on the olfactory bulbs, by preventing the air entering this portion of the nose. It is easy to see that nasal stenosis, from whatever cause, is far-reaching in its effects on the general health, and should be early relieved lest permanent, serious conditions may result therefrom. The proper treatment in early childhood may remove the tendency to the many pathological conditions that are sure to follow.

Except for the acute or chronic inflammatory conditions resulting from catarrhal inflammation, the treatment of nasal stenosis is largely surgical. It is frequently observed that many conditions combine to form the obstruction. This is especially true of septal deviations and hypertrophy

of the turbinated body, as well as of tonsilitis and adenoid vegetations.

We shall report to-night only those cases requiring surgical treatment, and shall bring to your notice as many varieties as possible.

*Case 1. Anterior hypertrophy of the turbinated body.* C. C., aged 14, has suffered since childhood from nasal occlusion, more or less complete, with a tendency to frequent coryza. He seems to be of a scrofulous diathesis. Respiration through the nose is quite impossible, especially in the morning. There is a tough, yellowish secretion from the nose in the morning, and he suffers from frequent acute attacks of coryza, at which time the nose is perfectly occluded. There is also dizziness, headache and loss of memory; lack of nasal resonance in the voice was also to be observed. He had also suffered for a long time from suppurative otitis. On inspection the turbinated bodies were seen to be hypertrophied anteriorly, almost occluding the nose, while the enlargement was not relieved by the application of cocaine. Three or four applications of electro-cautery acid applied on a sound, relieved the stenosis as well as the reflex symptoms resulting therefrom.

*Case 2. Posterior hypertrophy of the turbinated body.* Male, age 31 years, complained that for a year or more he had been unable to breathe through the nose, particularly on the right side. He also suffered from headache, dizziness and dullness of the intellect, while at times he had violent attacks of vertigo, in which he would become unconscious for a short time, especially when bending forward, as was required during much of his labor as a gardener. Indeed, he had become so bad that he was unable to perform any labor that required the stooping posture on account of the syncope. He had much tough mucus in the posterior nasal region which escaped through the cloacæ into the throat, causing much hawking and scraping of the throat, which had caused an irritation in the pharynx and larynx, with slight cough.

On examination I found a very large, purple hypertrophy of the posterior end of the turbinated body which completely filled the right posterior nasal space, and projecting behind the septum, obstructed a large portion of the left narium and much of the naso-pharyngeal space. After an application of a ten per cent solution of cocaine directly to the parts

with a cotton applicator, I removed the entire growth at a single sitting. This was done with the electro-cautery snare, operating through the nose by the aid of the rhinoscope mirror in the mouth. A severe hæmorrhage followed and which I was not able to stop for some time. It was not severe enough, however, to require posterior plugging, which is the only effectual means of arresting a severe hæmorrhage in this portion of the nose.

It has been my experience that, that by the use of steel instead of platinum wire as an electro-cautery, much of the hæmorrhage will be prevented, because the steel being a better conductor of the current does not become more than blue-hot, and causes a deep-seated eschar perfectly sealing the ends of the severed vessels, thereby avoiding this sometimes serious complications; while by the use of platinum wire in the snare, the surface is not only coated but absolutely decomposed, and is so friable that the blood-pressure behind it is sufficient to push its way through the coating of burned tissues and leave the cut ends of the vessels standing open. The cold snare should never be used in a severe case of this nature.

*Case 3.—Polypoid hypertrophy of the turbinated body.*—A young man of 20 complained that for a number of months he had been unable to breathe through the right side of his nose, and that he often suffered from "colds and stuffiness in the head. He had suffered frequently from headache, especially during the more acute symptoms. There was some nasal discharge which also varied according as the symptoms were acute or sub-acute. An examination revealed a large pedunculated tumor springing from the middle of the inferior turbinated body which completely filled the nasal space on the right side. It was quite red and of firm consistence but slightly erectile, as shown by the application of cocaine.

The growth was easily removed by the aid of the electro-cautery snare, and perfect freedom for the passage of air was secured. The operation was followed by an anti-septic solution applied with an atomizer during the healing process. This is an important part of the treatment of such cases, and if not promptly attended to, may cause an unpleasant complication.

*Case 4.—Deviation of the nasal septum.*—Girl, aged 15 years, says she cannot breathe through the left side of the nose at any time, and that much of the time she is unable to obtain breath through the right side also, and that she must resort to mouth breathing. She has the characteristic appearance of this pernicious habit well marked.

An examination shows an occlusion of the left nares due to a deflection of the septum to that side, perfectly closing the passage. She fell from a sleigh four years ago and injured her nose, and I am quite sure she sustained, at that time, a fracture of the septum with this result. The right side showed, as is often the case, a corresponding enlargement of the inferior turbinated body. After making two incisions through the septum, one extending from the posterior inferior angle of the deviation to the anterior superior angle, and the second at about right angles to the first, crossing at the apex of the projection. I forced the pieces into a straight line and held them in place with plugs of oakum. In this manner I secured a very good passage for air on the left side, while on the right I used the electro-cautery to destroy the hypertrophic tissues with good results.

*Case 5.—Congenital occlusion of the nose.*—A young lady 17 years of age says she has always been unable to breathe through the nose and shows the usual signs of the mouth breather. She was able to force air through the nose, but during quiet respiration always breathed through the mouth. She suffered very much from headache. On the right side I found the whole of the narrowed space filled by the inferior turbinated bone, while on the left the space was occupied by a shelf of bone which projected from the union of the septum with the superior maxillary.

I removed the bony projection with the nasal saw and in ten days removed the lower third of the turbinated bone on the right side in the same manner. The after-treatment consisted of an antiseptic spray until the cut surfaces were healed. During the first day I plugged the nose with antiseptic cotton in order to prevent hemorrhage. By the use of a ten per cent solution of cocaine there was but slight pain.

*Case 6.—Nasal myxomata causing nasal stenosis.*—Male, aged 40 years, has for two years suffered from a gradually increasing nasal stenosis. He is exceedingly uncomfortable on account of inability to breath through the nose as

well as from the headache and restless sleep that usually accompanies this condition. He was aware that he had been suffering from nasal polypi as he had once had them torn away, *a la* catch-as-catch-can, together with a large amount of nasal tissue; causing him great pain and a very severe hemorrhage.

I found the nose to be perfectly filled by a number of nasal polypi, which I removed without the slightest pain by the aid of cold snare and a ten per cent. solution of cocaine. The electro-cautery point was used on the basis of the growths.

I am certain that after having been once removed by the forceps in the manner formerly practiced, these polypi are much more difficult of cure. Such cases have usually lost their pedunculated form and have become attached over much of the surface by that operation.

*Case 7.—Nasal stenosis from adenoid vegetations.* Boy, aged 9 years, of lymphatic temperament, has never been able to breathe through the nose since early childhood.

Slow, difficult articulation, and a general stupid appearance, with noisy, restless sleep. By an examination of the naso-pharynx, I found it completely filled by a large mass of adenoid tissue which completely closed the posterior nasal openings. By the aid of the post-nasal forceps I removed the whole of the growth, under the influence of an anæsthetic.

The relief was most satisfactory as the boy was at once relieved from his difficult breathing and was very quickly restored to perfect health.

*Case 8. Adhesion of the soft palate to the pharyngeal wall.* Woman, aged 32, presented at the clinic on account of a very active, syphilitic ulceration of the throat of some months' standing. There was a long narrow ulcer extending from the soft palate to the larynx. The uvula was quite gone and there was an almost complete adhesion of the soft palate to the pharyngeal wall, leaving a small opening not larger than a small quill, in the center.

An ulcer was about to make sad havoc with the anterior portion of the soft palate.

Under the influence of Potassa Iodide and a local spray of Merc. Cor. 1.2000, the ulceration rapidly healed, while there was no more adhesion of the palato-pharyngeal surfaces.

After she seems free from the syphilitic poison I shall separate the soft pálate from the pharyngeal wall in order to relieve the oral breathing.

*Case 9. Nasal stenosis from hypertrophy of the tonsils.* A 5-year-old child was brought to the clinic because she had such difficulty of breathing that she was almost unable to sleep or eat. The obstruction was much worse in the recumbent posture so that sleep was especially noisy and fretful.

Nasal breathing was quite impossible except under the most favorable circumstances of position and with an effort on the part of the child. The speech was dull and thick. On examination of the mouth nothing presented in the pharyngeal region except two large hypertrophied tonsils which stood out like two great balls in the throat.

They really seemed to fill the whole of the pharyngeal space, but a patient with a growth in the throat learns how to dodge it and keep the breathing process going, even under very unfavorable circumstances.

I at once excised both tonsils by the aid of McKenzie's tonsilotome. She has been absolutely free from any trouble since.

These cases are but a few examples of the many such that come under the observation of the specialist, many of which have suffered for years, believing themselves to be afflicted with an incurable catarrh, an opinion often shared by their family physician.

*Discussion.*—Before the discussion of Dr. Dunn's paper was opened, the President, Dr. E. S. Bailey, said: It has been with much gratification that I have listened to this paper, not only on account of the merits of the essay, but also because it is the first paper on the surgical treatment of diseases of the nose that has been read before this society during its many sessions, and I consider it an index of the increasing interest taken in our Society.

DR. C. G. FELLOWS was then called upon by the chair to open the discussion. His remarks were:

I cannot add anything to the paper, as the cases have been selected with such care that the ground has been

thoroughly covered. Diseases of the nose and throat are of such frequent occurrence in Chicago and the North-west, that very few people are entirely free from some affection of this kind. If we attempt to treat these cases by internal medication alone we must necessarily fail, as many of them are amenable to surgical measures only. I had such a case in my office this morning. The patient, a young man, consulted me in regard to an accumulation of mucus in the throat causing a constant hawking, which annoyed him greatly. On examination I found several large hypertrophies on the posterior pharyngeal wall.

The use of the galvano-cautery is comparatively new here, it having been introduced by members of the profession returning from the European clinics.

I should like to ask the essayist's opinion with regard to its use in cases of chronic hypertrophy of the posterior pharyngeal wall; especially in those cases in which the thickening is sufficient to cause stenosis.

I saw this same cautery-handle in Dr. Dunn's office some time ago, and consider it a most excellent instrument.

DR. A. K. CRAWFORD: I am pleased with this report not only because it is the first paper of the kind that has ever been presented to this society, but because all of us know how many of these cases we meet with in this latitude. It is remarkable what a great variety of affections we find in so small a space as the nares and pharynx. The Doctor stated that he used the steel wire on account of its not heating so rapidly. I should like to know the results of its use in regard to the amount of pain caused by the operation? It is usually supposed that with the platinum wire at a white heat the operation is practically painless.

I am somewhat prejudiced against the use of the galvano-cautery, as so many patients have come into my hands after having been so treated by some specialist. They have all stated that the operation was anything but pleasant or successful. Many flatly declare that they were no better than before the operation, and that during the healing the wound was very painful. I cannot say what the

condition was previous to the operation or how successful the operation really was. I should like the Doctor to give the results of these cases later, and we could then see if the use of the galvano-cautery compares favorably with other forms of treatment, and with the results obtained in other localities. It may be that, in a latitude as intensely catarrhal as this, it is impossible to obtain as good results as in a more favorable climate.

DR. R. M. BARROWS: I would like to ask Dr. Dunn if he would advise the early excision of the tonsils? I have two cases in particular, children, subject to frequently recurring attacks of tonsilitis. I can relieve the trouble for the time by the use of the indicated remedy, but on the first exposure the trouble returns.

DR. OTTO POPPE: My experience with this class of diseases has been limited and my success has not been good.

DR. W. P. MACCRACKEN: Dr. Barrows has asked the same question that I had in mind. I should also like to know what class of remedies the Doctor has found best suited in connection with the surgical treatment of these diseases.

DR. H. N. LYON being called for, said: In regard to the material of which the electrode is made, I think the better results obtained from the use of iron or steel wire rather than platinum, are due, not to a difference in temperature, but to the fact that when brought in contact with the tissues and heated by the electric current, a decomposition of the wire occurs as well as of the tissues themselves. This would give us an oxide, carbonate and chloride of iron, and probably a sulphate and a trace of the other salts of iron. These are all valuable hæmostatics. The chemical activity of platinum being low and its salts possessing only slight powers of coagulating the blood, the hæmorrhage would be more free when this was used.

While the use of the iron wire in this locality is unattended with any serious disadvantages, one should be very cautious when the part to be operated on is exposed to view. Some of the iron salts formed during the operation,

the oxide especially, are insoluble and a dark cicatrix would be the result. As this decomposition of the electrode occurs only at the positive pole we can use a steel needle with impunity when it can be attached to the negative pole. For the removal of hairs I much prefer the steel to the platinum needle.

Prof. Groh, of Olmütz, (*Die Electrolyse in der Chirurgie*) advises the use of zinc needles attached to the positive pole when the parts to be destroyed are highly vascular. The chloride of zinc formed by the decomposition of the needle aids materially in controlling the hæmorrhage, the resulting eschar resembling that obtained from the chloride of zinc paste. If the heat of the zinc wire is sufficient to amputate the growth this wire would probably answer better than iron.

DR. C. G. FELLOWS. If I may be allowed another question, I would like to ask if the essayist advises the use of the galvano-cautery to promote absorption when the growths are small?

DR. E. S. BAILEY. During my service with a surgeon as an assistant, I saw many of those operations characterized by the doctor as catch-as-catch-can. One case in particular will serve to illustrate what we did in those days.

*Case 1.* The patient, a widow lady, came to the city for the removal of an unusually large nasal polypus. She was much inclined toward a society life, a great worker in the church, etc., and was fast becoming morbid on the subject of her impaired breathing. We promised to operate at 10 a. m. the next day, but on account of other work the operation was postponed. She remained in the office all day, and at last at 9 p. m. we administered chloroform and went for the polypus "catch-as-catch-can," assisted by a head-mirror, forceps, a pound of chloroform and a liberal supply of towels. The hæmorrhage was terrible—nearly as bad as an amputation at the hip or shoulder. At 11 p. m. she was still under the influence of the anæsthetic. The next day she quit the city and us as a firm. To make matters worse the growth returned. The vascularity of such growths is surprisingly great, and the modern methods of

operating are calculated to remove the growths with the least hæmorrhage.

*Case 2.*—I was recently consulted with reference to a severe headache located over the right eye about two inches above the ridge and affecting only a small area. I declined to prescribe until I could make an examination of the nasal passages. A few days later the examination was made and we discovered so complete a stenosis of the passages on that side that it was impossible to pass a fine silver probe.

Many failures in the treatment of headaches I believe to be due to unrecognized nasal stenosis. Many cases of so-called "eye strain" are due to the same cause. It is now quite fashionable for patients to imagine they have this trouble and to go to some eye specialist rather than to their regular physician. I have lost patients in this way. They go somewhere, and I suppose the oculist gets them. I hope so, for he will recognize the trouble and be able to benefit them. My attention was first called to these cases when being with Dr. Dunn in London. He directed me to Dr. MacKenzie's throat hospital, where scores of these cases are treated.

I am in favor of the galvano-cautery only to a limited extent and then in the more chronic troubles. I do not think it indicated in the milder cases. I use a storage battery of 100 ampères capacity, charged by the Edison dynamo; with this I can heat the cautery point in a few seconds. I recently lost the entire charge by the fusing of the wire point on removing it from the tumor. There was a sharp flash and it was over, not a trace of the charge being left in the battery. Such accidents should lead us to be cautious in the use of this agent, or we may work serious harm to the patient by an improperly regulated current.

One great advantage in its use is the comparative freedom from hæmorrhage. We used to control the bleeding by inserting a flexible catheter and filling the nose with water as hot as the patient could bear it. Then with a tuft of cotton held in the dressing forceps we removed the clot. After this we were obliged to wait to determine whether the hæmorrhage would begin again before continuing the operation.

In the removal of these tumors by electrolysis or by means of the electro-cautery the idea is to so destroy the tissues at the base of the growth that its nutrition is cut off. If this is successfully done they will not return.

An old method of removing a wart was to insert a needle into its base and then heat the free end of the needle in the flame of a spirit lamp. Sufficient heat was thus communicated to the growth to destroy its nutrition and, as a result, it soon came away. The results from the use of the electro-cautery are practically the same.

DR. DUNN. In closing the discussion, Dr. Dunn said: In regard to the pain from the use of the steel wire, there is no pain from this more than from the platinum wire. I always use a 10 per cent. solution of cocaine applied to the site of the operation by means of the cotton applicator. As strong a solution as this should never be applied by means of the spray. I believe more cocaine will be absorbed from a 3 per cent solution in spray, than from the former solution applied on cotton.

I learned the use of the steel wire by experience. On one occasion my supply of platinum wire gave out, and having nothing else I was obliged to use the steel. It did the work so well that I have since used it in preference to platinum.

We understand the hæmorrhage when we remember the blood supply of the nose. The vascular tissue there is chiefly of the erectile type, and as erectile tissue is but poorly supplied with fibrous and muscular tissue, the vessels do not readily contract after incision. The abuse of the cautery is very common.

*Case.*—A patient recently came to me suffering from syphilitic ethmoiditis. The pain was intense, and he had been to the Hot Springs, believing that it could be relieved by the treatment there. While there some instrument, which the patient said resembled a glove-stretcher, was used on the nose. Not being benefited there he returned to the city and consulted one of the advertising specialists who applied the cautery to this acutely inflamed surface.

As a consequence the trouble was so augmented that the patient could do little else but walk the floor.

In proper cases bad results do not follow, but a transient neuralgia might result in a few cases.

Most of the cases I have reported to-night were of long standing, and have been permanently relieved. Of course new growths may form, but this is not due to the operation as the liability to such troubles remains after their removal.

An early excision of the tonsils is not advisable, and at all times we must distinguish between a chronic inflammation and actual hypertrophy. In the latter condition new cell elements have formed and the glands have lost their functional activity.

This condition does not occur until the previous inflammation has existed for from six months to two years. During the acute stage the indicated remedy should always be used. We may remove the tonsils if the acute exacerbations are of frequent occurrence; if the hypertrophy is so extensive that they come together; or if one is so enlarged that it nearly fills the fauces, and the surface is rough and nodulated. If the surface is smooth and normal I would advise treatment with a view to saving the glands.

Post-nasal polypi are very rare. They may be removed by means of a bent snare introduced through the mouth, the throat-mirror being used in order that we may see what we are doing. The curved throat forceps may also be used in the same manner. It may be necessary to use a palate retractor, or the palate may be brought forward by an elastic band passed through the nose and then brought out at the mouth, the ends being then fastened together.

In answer to Dr. Fellows' question, the electro-cautery works well in adenoid growths if used with care.

*Case.* One case will serve as an illustration. The patient, a well-known singer, had a patch of adenoid vegetations on the posterior wall of the pharynx that seriously interfered with vocalization. The mucus from this would fall into the larynx whenever there was an exacerbation from

catching cold. This would start up a laryngitis. I operated for this trouble during the winter and succeeded in relieving her sufficiently for her to rejoin her troupe. In the summer she came down to my place in the country where the treatments were continued, entirely curing the trouble. This season she has been entirely free from any affection of the nose or throat.

As a usual thing adenoid vegetations are best removed with the forceps. There is no liability of injuring the parts if one remembers the anatomy and is careful to see what he is doing by the aid of the throat mirror. If pedunculated the snare may be used. In this region the hæmorrhage is not as severe as in the nose. In operating on children an anæsthetic should be given.

Many cases of vertigo, neuralgia, etc., are due to nasal troubles. If a growth presses on a vaso-constrictor nerve, vertigo will result. If on a nerve of sensation, pain.



Galvano-cautery with pistol-handle.

Dr. Dunn then showed to the Society a modification of the ordinary galvano-cautery handle as used for nasopharyngeal work. The chief advantage over other exist-

ing forms being in the shape of the hand-piece. This was bent at such an angle that the body of the instrument was removed from the direct line of vision, thus permitting the use of the throat mirror at the same time.

VOLUNTEER PAPERS: CASES IN OBSTETRIC PRACTICE.—BY CHRISTOPHER BOLLEN, M.D., OF PORT ADELAIDE, S. AUSTRALIA.—

*Case 1.*—Mrs. R., a middle-aged woman, came to me to know if I would attend her in confinement. She had four children, but lately had such bad times that upon going to her family doctor he had flatly refused to attend her in the coming event.

Upon questioning her it seems she suffered so from hæmorrhage both before and after her last confinement, he said this time she would not live. I took the case, and two months later was sent for about 7 o'clock in the evening, to find that the dilating pains had just started and the os was enlarged to the size of a six-penny piece. Left her on puls. 6 every half hour, with directions to be sent for immediately if anything new cropped up—especially hæmorrhage.

Sent for at 11 o'clock same evening and found a few drops of blood had come away. Upon examination found os as large as a five-shilling piece, and just inside of the neck of the uterus a round lump. I hardly know how to describe it except that everything seemed normal but this lump the size of half a hen's egg attached to the side of the neck of the uterus, and right in front of the head.

I kept her on puls. 6 and watched the case. As the os dilated the hæmorrhage gradually became more severe, but not enough to be alarming. At last when I began to think of putting on the forceps I was able by pressure on the fundus of the uterus to make the head engage, and from then the hæmorrhage ceased, until the child was born naturally. Hæmorrhage immediately followed the birth of the child, and so forced me to deliver the placenta. Upon its delivery I found it quite perfect except one edge was crushed out of shape. This crushed edge I presume was the part caught between the advancing head and the bony pelvis.

She made a rapid recovery, and I have been her family doctor ever since.

*Case 2.* I was called in about 10 o'clock one night to see this case in consultation with another doctor.

A middle-aged woman had been in labor since 8 o'clock in the morning. He had tried the forceps three or four times without success. Upon examination I found a prolapsed cord, a very small pelvic canal—almost enough to be a deformity—and an exceedingly large head, with the face to the front. Upon using the forceps I found every time they slipped over the head, having a tendency each time to go toward the occiput. After trying twice we decided to call in further advice, as it seemed a case for craniotomy, the mother being so exhausted.

After putting her well under the effects of chloroform a perforator was introduced and the child's cranium pretty well evacuated. Then not having a craniotomy forcep we had to proceed to the act of turning the child. This was done in the ordinary way, and we delivered her of a large male child. She is making a tedious recovery, and as it is now three weeks since the operation, and she is able to be up on a couch, I think she will do well.

*Case 3.* Mrs. B. First labor. Everything went off well until I came to deliver the after-birth, when try as I would I could not get it away. After well washing my right hand and oiling it I passed it into the uterus and found the placenta well detached except that a broad band of membrane extended from it up to the fundus of the uterus, where it was attached. This I followed up and detached. The placenta was then immediately delivered and she has made a rapid recovery, temperature never being once over 99°.

2. ESSENTIAL PAROXYSMAL TACHYCARDIA. BY DR. W. F. ROBINSON.—A certain Dr. Bouveret has lately published in one of the leading French journals, the description of a singular cardiac affection in which the heart-beats often exceed 200 per minute. In the interval between the attacks the heart returns to its normal condition, showing that the trouble is simply a functional disturbance of the motor-nerves of that organ. The number of cases of this disease already observed is still very limited. The author presents two from his own experience, in addition to which he has found nine cases reported by others. In all the observations are found the same characteristics which make this form of tachycardia a separate affection. These symp-

toms are the freedom from discomfort in the intervals between the attacks and the organic integrity of the heart, as well as that of all the other organs.

Dr. Bouveret has clearly distinguished this malady from the tachycardia produced by organic changes in the heart, the bulb, the pneumogastric nerves and the neuroses of the cardiac nerves, such as angina pectoris, palpitations and Basedow's disease. It seems, therefore, worth a while to give a short *résumé* of this remarkable paper.

As a result of some strong emotion, of fatigue or even without appreciable cause, the heart-beat suddenly increases from the normal to the rapid rhythm of the disease. The attack is sometimes, but not always, announced by dizziness, a feeling of constriction at the neck and at the epigastrium. The face grows pale, the respiration becomes slightly more rapid, but is rarely accompanied by dyspnoea. The patient experiences a sensation of weakness, but the general symptoms are not severe enough to oblige him to remain in bed. There may or may not be present a sensation of constriction in the præcordial region, but the anguish and suffering of angina pectoris are never present. The pulse-beats reach as high as 190, 200, or they may even attain the incredible figure of 300 per minute. The heart-beats are generally regular and resemble, by their short and sharp sounds, the beat of the foetal heart.

As to abnormal sounds, a slight, systolic murmur may occasionally be heard at the apex. The hand placed upon the præcordial region does not feel the shock of the heart-beat, but a rapid vibration which is also perceptible to the eye. The cardiac dullness is increased, which shows that the cavities of the heart are dilated. The pulse is imperceptible, and it is only with great difficulty that occasional pulsations may be perceived in the form of slight undulations. Sometimes it disappears altogether and can only be felt in the large arteries, such as the carotids.

When the pulse becomes stronger it is a sign that the end of the attack is approaching. The extreme rapidity of the heart-beats prevents this organ from emptying itself completely, from which come the paleness of the skin and the phenomena of venous congestion, the swelling of the jugular veins and the cyanosis of the lips and cheeks. These are about the only symptoms to be noted. The pupils remain normally dilated and there are no vaso-

motor troubles. The appetite is diminished and some patients are troubled with nausea. The quantity of urine is about normal and does not contain albumen. The liver and spleen retain their normal size, and there is present neither ascites nor œdema. The temperature is either normal or slightly lowered.

The duration of the attack is variable and of great importance on account of possible consequences. Thus Dr. Bouveret distinguishes attacks of long and of short duration. The later last from a few minutes to four or five hours. The attack finishes abruptly in a few seconds by the lowering of the number of pulsations down to the normal. The progressive diminution in the number of the attacks may take place, but it is rare. The malaise disappears immediately and there remains only a slight depression of the psychical forces, which soon disappears in its turn.

The serious attacks may last from five or six days to several weeks; however, there may be a return to the normal for a few hours or even a day or two. What distinguishes this attack from those of short duration is the addition of secondary symptoms, the result of the prolonged duration of the attack. The cause of these is to be found in the distention of the cardiac cavities, which gives rise to cardiac and respiratory difficulties that are more or less serious. The attack once finished, the slightest cause is sufficient to bring about a repetition of the same.

The signs of cardiac dilatation do not appear until the attack has lasted from four to six days. The undulatory movement of the pulsation becomes perceptible to the hand, from the apex of the heart to its base, and may extend even to the epigastrium and the right side of the sternum. The cardiac dullness is also extended in these same proportions and recalls that produced by pericardial effusion. One cannot attribute the dullness to this cause, however, for the heart-beat can always be distinctly felt under the hand, and, moreover, it (the dullness) disappears in a few hours, when the attack is past, which is incompatible with the theory of effusion. The distention of the cardiac walls takes place little by little during a period of a few days. On auscultation the heart-sounds are the same as during a short attack only they are heard over a greater extent of surface. A soft murmur conceals the first sound.

The secondary symptoms appear first in the lungs. A frequent annoying cough, followed by a mucous expectoration

which soon becomes tinged with blood. The patient may be affected with genuine hæmoptosis, after which the sputa remain brownish and viscous. The respirations may reach 40 per minute and the dyspnœa becomes intense. Auscultation gives us rales, sonorous, crepitant and sub-crepitant, friction sounds and bronchial respiration. These symptoms are readily explained by the congestion and œdema of the lungs, resulting from the increased pressure in the pulmonary veins. It is this intense congestion of the lungs which determines the grave lesions of these organs, to which may be added hæmoptysis, which sometimes puts the life of the patient in danger.

These lesions disappear with the cessation of the attack, even to the physical signs given by auscultation. The stasis in the general venous circulation has for a result an intense cyanosis depending upon insufficiency of the tricuspid valve. There may be observed also a venous pulse in the jugulars. The arterial anæmia and venous stasis produce cerebral troubles, indicated by insomnia, bad dreams and delirium.

This last symptom may be owing in part to the reduced quantity of the urinary secretion. The liver and spleen are congested and considerably increased in volume. The right hypochondria becomes painful on pressure. A further result of the prolonged venous stasis is œdema of the lower extremities. In the more serious attacks the digestive troubles are constant; they consist in complete anorexia, more or less severe thirst, nausea, vomiting and diarrhœa. The tongue is moist but heavily coated. The urinary secretion is always diminished, owing to the decrease of the arterial tension. The urine is of high specific gravity and strongly colored. Albuminuria is often present as well as a light grade of hæmaturia.

The secretion of the perspiration disappears during the whole length of the attack, but if the termination is in collapse the extremities are covered with a cold sweat. In the short attacks the temperature remains normal. In the long attacks, owing to the secondary lesions in the lungs, it may increase from 1 to 3 degrees.

During the attack the patient experiences ordinarily, prostration of strength, a general sensation of cold and a feeling of constriction in various regions of the body. The ischæmia of the heart-muscle may also produce painful symptoms recalling those of angina pectoris and may even

cause the heart to cease beating. Ordinarily the patients are confined to bed only during the attacks.

The course of the disease is essentially paroxysmal and the patient is constantly in fear of a fresh attack, as the epileptic remains always exposed to a convulsive seizure. In the intervals between the attacks the patients experience no symptoms either in the heart or other organs and the general health remains good. They therefore resume their occupations and may even support those of a trying and painful nature. As the disease progresses, however, the attacks follow one another more and more closely and the resulting weakness is more and more marked.

Up to the present time, it is difficult to fix in a manner at all definite, the duration of the malady. Certain patients have remained entirely free after a few attacks, others have remained subject to them for many years.

The severe attack may terminate favorably by the sudden return of the heart-beats to the normal. The transition is made by two or three cardiac contractions, slow but energetic, and sometimes exceedingly painful to the patient. All the secondary symptoms disappear at the end of a few days, the urinary secretion is reëstablished at the end of a few hours and is even increased during the first few days of the convalescence. As to the heart there remains no permanent lesion whatever, the dilatation disappears completely, but the organ remains extremely irritable and the acceleration may return under the influence of the slightest cause, or when the patient gets up.

Judging by these cases this form of tachycardia is a serious disease. Out of eleven patients four have died in syncope or collapse, and of the seven remaining one only was cured.

The prognosis depends upon the duration of the attacks as it is this which gives rise to the grave secondary symptoms. According to Dr. Bouveret the following signs should be considered of evil omen: Tendency to syncope, intense pulmonary congestion, præcordial pains recalling those of angina pectoris, finally the facility with which the attacks return.

Among the etiological conditions tending to produce the disease may be mentioned with special emphasis, physical and mental overstrain. The effect of powerful emotions and that of cold are the most common exciting causes. These latter are very various and slight if the patient has already had numerous attacks.

It should be said that among the antecedents of the patients, hysteria, neurasthenia and nervous heredity in general, seem to be entirely lacking. Although paroxysmal tachycardia associated with aortic lesions, resembles closely the form which we have styled "essential," it differs from it on account of the sympathetic troubles accompanying it; such as the sudden dilatation of the pupils, the redness of the face, followed by palor, etc. In short, essential tachycardia in its paroxysmal form is an affection by itself, to be distinguished from all other tachycardias by its phenomena limited exclusively to the motor sphere of the heart, by the extreme rapidity of the pulse during the attack, and finally by the suddenness with which the attack begins and ends.

What is the nature of this affection? The only autopsy that has been made tells us nothing, for it gives us only negative results. The course of the disease shows that it is purely a functional trouble. Considering all the facts Dr. Bouveret is constrained to admit the existence of a special neurosis, characterized by the localization of the nervous troubles in the cardiac centres and branches of the pneumogastric. The inhibitory apparatus of the heart is alone affected. A cause, even though it be slight, such as physical fatigue, or a lively emotion, is sufficient to exhaust for a certain time the inhibitory machine. Sometimes the erect position alone if maintained for any length of time is sufficient to bring on an attack, probably because the ischaemia of the bulb thus produced exhausts the inhibitory centres.

The treatment should have for its object to combat all the causes that might produce the trouble, as for example, all causes of weakness. Stimulating beverages, such as tea, coffee and alcohol, should be prohibited. During the attack the patient should remain in bed, or at least keep quiet. He should avoid all sudden movements for fear of bringing on a fit of syncope. Strong mental emotions should be avoided, and finally the patient should be slow in quitting the bed.

Medical treatment has been proved to be without value. Digitalis, nitrite of amyl, caffeine and nitroglycerine have been tried, but the results are far from satisfactory. One of Dr. Bouveret's patients was relieved by injections of morphine, but they had no effect upon the attack itself. In three cases where it was employed the compression of the pneumogastric nerve on the left side, on a level with the

thyroid cartilage, succeeded in reducing the exaggerated pulsations to the normal. In fact it is the only treatment that has produced any real effect, but the cases are still too few to form a just appreciation of its value.

3. HOW TO PREVENT THE SEQUELÆ OF SCARLATINA. BY DR. O. W. CARLSON, of Milwaukee.—*Concluded from page 96.*—I rely chiefly, but not exclusively, upon two remedies *viz.* strammonium and cannabis sativa. The former is given in the third decimal dilution for the delirium that is likely to occur in bad cases during the second forty-eight hours; and the latter in the second decimal, all the way through for its beneficial influence in keeping up a free and salutary flow of urine.

When the fever has subsided the pack and the rubber sheets are omitted and the patient is dressed in dry, warm night-clothes and placed in bed in the ordinary way. In two or three days from this time, when the period for desquamation has arrived, I have the nurse anoint the child every evening with cocoa butter and sponge it off every morning with a mixture consisting of equal parts of hot water and alcohol. This cleanses the skin and keeps it soft, and its use is continued so long as there is any sign of desquamation. The child is well-fed from the first, milk being preferable as an article of diet.

A marked effect of this treatment is (1) that there is so little desquamation of the cuticle as really amounts to nothing, excepting in the case of the exposed hand; (2) that it aborts all glandular enlargement, and all swellings and discharges from the eyes and the ears, all bloating of the abdomen and dropsical swellings of the face, hands and feet, and all renal involvement of a serious character. With its use there are no "after-claps," which parents and those who are most interested always associate with the disease, and naturally fear and dread so much.

By this treatment the skin is kept so actively engaged in the elimination of the poison that it relieves the kidneys and the glandular system from the danger of being over-worked, a condition which allows them to perform their

own very important service in a physiological manner. The success of the method, however, is in proportion to the care and thoroughness of the application. I am fully satisfied that it is much more reliable than any other plan can be which disregards the scavenger function of the skin-emunctories and depends entirely and exclusively upon internal medication.

4. SOME CLINICAL POINTS IN DIABETES. BY DR. W. F. ROBINSON.—Dr. Elb, of Dresden, claims that most diabetic patients can assimilate a certain quantity of carbonaceous material (hydrate of carbon) without its passing over into the urine as sugar.

That, moreover, it is much better for the patient to take this quantity, however much it may be, on account of the better nourishment of the body which results. The main and most important point, therefore, is to determine for each individual case how much carbonaceous food can be taken, and when this is once settled, it is all the better for the patient to have a varied diet, always provided, that this boundary be not over-stepped.

Dr. Elb has made a practical application of this principle in a large number of cases and has always obtained excellent results therefrom.

As to remedies, the Doctor has confidence in the well-tried drugs, arsenicum, uranium nitricum and creosote. He also recommends zzygium jambolinum and helonias, the latter in the first decimal trituration, as he has found the dilutions to be without value. As to phloridzen he considers it to be of no service in this affection.

Good results are to be obtained by the use of drugs in this disease, but a permanent cure can only be made by means of proper attention to diet, exercise, etc. Prolonged and active exercise in the open air, so long as it is not carried to excess, has an extremely favorable influence on the amount of sugar secreted. If the quantity of sugar secreted by a patient, eating a certain amount of carbonaceous food, be exactly determined, it will be found, that if this patient takes a liberal amount of exercise in the open air, the sugar secretion will either be greatly diminished or disappear altogether. This exercise should consist partially of mountain climbing. Sugar is to be found in the urine of diabetics as soon as an hour after a meal and two hours after the quantity of sugar secreted reaches its maximum. On this

account, the sooner after the meal the exercise is taken, the better. The Doctor allows his patients all kinds of carbonaceous food, such as cake, pastry, potatoes, etc. Only the general quantity requires to be regulated. Patients undergoing this treatment soon become cheerful and better pleased with life, in pleasant contrast to the usual melancholy of diabetics.

5. THE EQUALITY OF THE SEXES IN PULMONARY DISABLEMENT. BY DR. A. K. CRAWFORD, CHICAGO.—Having been appointed a committee of one by the Clinical Society to answer a question propounded by the President, I beg leave to offer the following brief study as my report.

The question which the Secretary handed me reads as follows: "Instances are reported of patients who have lived for a greater or less period of time, and have enjoyed comparatively good health when having the use of but one lung. Have such cases ever occurred among women?"

In considering this problem, the first thing which suggested itself to my mind was what are the diseases which will bring about such a condition of the lungs? Next, among this number is there one to which woman is not liable; and third, are there any physiological reasons for supposing that man can exist with less pulmonary capacity than woman. Finally, what does clinical experience teach us the facts are in this question of sex?

Did I wish to state the proposition in a breath I might say, "May the army of one-lungers be written in the feminine as well as the masculine gender?" And, simple as it looks, it is wonderful what an expanse of pulmonary pathology it is necessary to review before anything like an intelligent answer can be given. Pulmonary consumption, croupous pneumonia, caseous pneumonia, cirrhosis or interstitial pneumonia, pleurisy including hydrothorax and empyema, atrophy of the lung, and acquired atelectasis are all capable of destroying the function of a lung, and certainly no one will question woman's right to become the victim of each and every one of these diseases. As to the possibility of a woman living with as little respiratory capacity as a man, I can think of nothing that precludes such an idea. It may be that there existed in the mind of Dr. Bailey's lady friend, when she asked him for information on this point, that her sex must needs have more lung capacity than the doctor's on account of the acknowledged feminine proclivity to talk, and that one lung would scarce furnish the requisite amount of

air in such a case. We will be more generous and say that, physiologically, one lung is sufficient for the aëration of her blood, and will at the same time furnish her with as much wind as is befitting her to use in speech.

It is impossible that any one physician's experience should furnish testimony enough to settle the question at issue, for the number of such patients coming into one's private practice must be at best very few indeed. Therefore I searched any and all statistics within my reach, furnished by eminent pathologists from out their vast hospital clientele, in the hope that some definite numbers might be found, to set the question at rest. But nothing of the sort came under my notice. The closer the records come to the point where, as a result of a destructive pulmonary complaint, a whole lung or a large part thereof became useless, the less, seemingly, did the question of sex enter into them. In fact, while age, heredity, etc., received due attention from the author, sex was ignored. Now, it appears to me, that knowing how closely the prominent clinicians note all manner of conditions and side issues in their bedside studies, it would be most remarkable if only males should present themselves in this condition and no special reference be made to it. The impression upon my mind, then, was simply that men and women suffered alike in the extensive loss of lung tissue, and that their chances were equal in the prolongation of life after a lung was lost.

This, of course, is only an inferential argument in favor of equality of the sexes in this particular pathological state, and exception may, justly enough, be taken to this manner of answering the question. Nor do I consider this a satisfactory disposal of the matter.

But before leaving it allow me to offer a leaf from out my own observations. First, I think I can adduce such cases as will sustain the deduction drawn above, and next I may offer an instance or two of proof.

Among the acute diseases where there is a temporary loss of the function of one lung I remember distinctly the case of a young woman whose right chest was flooded with serum in consequence of a violent attack of pleurisy, and who had been in this condition for four weeks prior to my seeing her. Another week was wasted trying to bring about absorption by internal medication. Then aspiration was resorted to, and I drew off some forty odd ounces of amber-colored fluid without then emptying the sac, and re-

expansion of the compressed lung, and recovery of the patient readily followed.

From this I am certain that the temporary loss of one lung can be borne fully as well by a woman as by a man.

In pulmonary consumption of tubercular origin it would be a rarity to find a case well advanced that did not present signs of disease in both lungs, so that this, the most common form of destructive lung disease, tends little to furnish cases for our present study. But it is not uncommon to find cases in this class who, undoubtedly, have lost as much or even more than the amount of respiratory tissue contained in one side of the chest, and as not a few such instances have come under my notice of women living thus for years, we might again infer that had the disease process been confined to one side, the lung in that side would have been totally useless and these women would have existed no less comfortably.

The only positive proof I have to offer is the record of a case published\* years ago of a woman, fifty years of age, whose right chest was shrunken and dull from apex to base, reaching absolute flatness of percussion at the base and back. The other signs of solidification, remitus, tubular breathing, bronchophony and lack of expansion were all present to verify the loss of lung function. The only portion of this lung which gave a sign of admitting air was near the bifurcation of the bronchus, and this admitted only a broncho-vesicular murmur, high pitched and prolonged. There could not be the slightest doubt that this lung was as worthless as a carious tooth to this woman, yet she lived and was able to be on her feet, attending to household affairs, with one lung gone, and the other seriously involved.

My *confrere*, Dr. H. B. Fellows, has related to me a case in his practice, of a woman, too, whom he was called to examine, as consultant, for heart disease. In listening to the history of this patient he was regaled with a story, in which he put little faith, of how years before the good lady had been very ill with some pulmonary trouble, that her side had been opened and "the lung run out." Upon stripping the chest he found a scar in the left side, above the floor of the diaphragm, and a perfectly flattened immobile chest wall, which emitted as he remembers, no sound of respiration. The heart trouble ended her days, but, meantime, for several years she had managed to remain in the land of the living possessed of but half her normal respiratory organs.

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\*See The CLINIQUE, vol. VII., p. 35.

## Hospital Notes.

### CLINIC FOR THE MEDICAL DISEASES OF WOMEN.

SERVICE OF PROF. E. STILLMAN BAILEY, M. D.

FIRST SERIES.

BEING A REPORT OF ONE HUNDRED AND FIFTY CASES TREATED IN THIS CLINIC, COMPRISING CLINIC NOS. FROM 20,300 TO 20,449 INCLUSIVE.—A strict classification of diseases has been observed, and only such as belong to the diseases peculiar to women, which require and receive *medical* attention exclusively, are enumerated in this report, all other female patients presenting themselves have been referred to the clinic on gynecological surgery.

In the large clinical centers a great number of patients are transient, or attend irregularly, or desert when improvement begins, or tramp it to some other place. These patients in this report are very few—their cards having been surrendered to others. There is much of interest of a general character that can be gleaned from such an intelligent class of patients as it has been my good fortune to have attend this clinic.

The average age of puberty was fourteen and four-tenths years; over thirty per cent. were foreigners, and the average age of puberty with them was a little over fifteen years.

The average number of years of menstruation in those who had passed the climacteric was thirty-two and three-tenths. The average passed the climacteric during the forty-sixth year. One had finished menstruation at thirty-nine years of age and one at the fifty-sixth year. Fifty-four per cent. of the number reported menstruated regularly and normally every four weeks. The extremes are: one patient had menstruated normally every thirty-five days, and one every seventeen days; twenty menstruated every twenty-

one days. The average duration of the menstrual flow was three and nine-tenths days. Extremes: four per cent. were sick for one day only, thirteen per cent. for two days and fifteen per cent. were sick for seven days; four per cent. menstruated for ten days, and one patient was sick for fourteen days regularly and suffered nothing. Thirteen had irregular and scanty menstruation and another thirteen had irregular and profuse sickness. Seven complained of a very offensive flow. It is extremely difficult to obtain accurate data regarding the length of the menstrual period, and I do not know that it of itself is a very important factor, if it be found to be confined within certain limits. My experience is, in trying to find out accurately, that the patients themselves do not really know; very little attention is given to any of the physiological features of menstruation if the patient does not actually suffer. My percentages differ quite widely from others that are printed in the text-books, mainly in a large percentage of those who flow for one day only, and a smaller percentage of those who flow for seven or eight days. Thirty-two complained of dysmenorrhœa. Eight patients were very ill from pain from one to two days prior to the flow; two suffered for six days at the time, being constantly in bed and "lucky if not delirious," and four suffered tortures for four days during the flow. They all dreaded the returning period because of the pain they were sure to suffer. I may add that those who applied for treatment for this class of trouble were very materially benefited in this clinic. Some have been entirely cured.

Twenty-four patients were unmarried and one hundred and twenty had been married. The average married at twenty and a-half years of age. Eighty-six had given birth to three hundred and sixty-nine children. The average family had four children. Extremes, one family was happy in the number of twelve and one mother had had eighteen living children. This patient has not passed the climacteric and dreads another approaching confinement.

Of the thirty-four married and childless women quite a number had suffered either from intentional abortion or

traumatic miscarriage. Four consulted me for their sterility. The causes were found to be, one a very irritable vaginismus from specific causes that had existed for years. She had endured many methods of treatment and surgical operations without relief; one of retroflexion, and in two cases the causes were unknown. Forty-six had suffered from miscarriage, some for six times, and one reported that it had been so often she could not tell exactly but thought it must be "over a dozen times." Eighteen mothers dated their present illness to the crime of abortion or the misfortune of miscarriage. Twenty mothers had not been well since the birth of their first baby, fourteen from the second, three from third and one from the sixth. One has been constantly ill since the birth of twins, one from triplets and one from a miscarriage with twins at the fourth month. The youngest mother was fifteen years of age.

Nearly every other mother had some form of uterine displacement. Thirty-five suffered from prolapsus uteri, five from anti-version (this class of versions did exist and was demonstrated before those competent to judge, and the effort to rule out this form of displacement would be a failure with these patients for examination), five cases of anti flexion acute, fourteen of retro-version and four of retro-flexion. Extremes, two cases of procidentia, one complete, of recent origin and one complete of twenty years' duration. Five cases of prolapsus were accompanied with prolapsus of the bladder and nine with prolapsus of the rectal wall, and seven with both cystocele and rectocele.

Forty-two patients complained of a troublesome constipation, two of anal fissures, eighteen of hemorrhoids, and four with alternating diarrhoea and constipation of an intractable character.

Eighteen patients had either acute or chronic cystitis. Two suffered with urethral caruncle. Twelve patients had persistent leucorrhoea, one patient steadily declaring she had suffered in this way for thirty-four years. Twenty one mothers had sustained extensive lacerations of the cervix and perineum. Six had sub-involution of the uterus, four-

teen had ovaralgia, two salpingo-ovaritis, one cystic ovary, two cases of ascites, twenty-seven had pelvi-metritis, twelve endo-metritis, twenty-nine cervicitis, one case of vulvo-vaginitis, one of Graves' disease. Two cases of vaginismus, pruritus vulvæ, syphilitic condyloma, phlegmasia dolens. Three cases each of pelvic peritonitis, pelvic abscesses, epilepsy depending on traumatism affecting the generative tract, hysteria, vaginitis, salpingitis, interstitial fibroids. There were four cases of chlorosis, eight of menstrual headache and eight of disorders attending the climacteric.

The enumeration is not complete as to all the kinds of disease noted in the clinic, but rather to the relative number of cases in each class. It is interesting in one way to compare this experience with that of others. Thus, Emmet says, "at least one-half the ailments among those who have borne children are to be attributed to laceration of the cervix." Pallen claims that "forty per cent of women with uterine disease have a lacerated cervix." Goodell states that about one out of every six women suffering from uterine diseases has an ununited laceration of the cervix. The experience recorded here is that twenty-one out of eighty-six patients, who had given birth to one or more children, had sustained an ununited laceration of the cervix, or very nearly twenty-five per cent. The lacerations were both deep and extensive and of such a nature as to produce symptoms for which treatment was necessary. The number of prescriptions made and local treatments given was six hundred and eighty. The instruction in this department was given in the way of general clinic work before the entire class of students and also in the presence of the sub-classes.

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## Clinical Reviews.

TRANSACTIONS OF THE TWENTY-FIFTH SESSION OF THE HOMŒOPATHIC MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA, held at Pittsburg, Sept. 17 19, 1889: pp. 320.

This well-printed volume of 320 pages contains forty-one clinical papers that have been furnished by the diligent workers attached to the several departments of medicine and surgery in the bureaus of that Society. In every case the essays are brief and practical, and deserve to be kept where we can get at them for reference and counsel. That the good Fellows in the Quaker State are vigorously at work, and that somebody has carefully organized and edited that work, is evident in every one of these pages. There is next to nothing of the dubious haze of careless writing, no getting lost in a jungle of words, no wrangling over non-essentials, but a straightforward, persistent and practical aim that gives what might be called the Pittsburg stamp to the whole production.

The Address of President Trites, whose recent death we all deplore, is given in full, and is a manly and masterly contribution to our current literature. It is a real pity that such a faithful disciple could not have lived to enjoy all the medical rights to which he was so justly entitled.

ESSENTIALS OF GYNÆCOLOGY. *Arranged in the form of Questions and Answers, prepared especially for students of Medicine*, by EDWIN B. CRAGIN, M. D., Attending Gynæcologist to the Roosevelt Hospital, etc., with 58 illustrations. Philadelphia: W. B. Sanders. 1890; pp. 192.

It accords with the fitness of things that this jolly little book should be issued at a season when medical questions are more plentiful than blackberries, and just when our students are struggling to find answers to all sorts of interrogatories, sensible, scientific and sterile. This is No. 10 in the list of Sanders' Question-compends, and it is no small praise to say that it is the best in the lot. Whoever can answer half the questions given herein in a direct and rational manner, knows a thousand times more about gynæcology than our teachers did thirty years ago.

INTESTINAL SURGERY. BY N. SENN, M. D., PH. D., Professor of the Principles of Surgery and Surgical Pathology, Rush Medical College, etc., etc. Chicago, W. T. Keener, 1889; pp. 269.

Somebody's criticism of the play to the effect that "if there had been more death in it, it would have been more life like," will hold with reference to much that has been written of the peritoneal surgery of our own time. But it will not apply to the clinical lessons that are taught in this book. Luckily the incidental bloodshed has not involved the loss of human life. The practical surgeon who familiarizes himself with the details of these original experiments will not be tempted to ingraft new fashions of operating upon the old forms of physiological belief concerning the repair of the alimentary tissues when they have been wounded or traumatized. Indeed the sending forth of this modest volume by the chief medical publisher in the North-West marks an era in the development of intestinal surgery, and we are all very proud of it.

The first part of the book contains a *résumé* of the best literature on the surgical treatment of intestinal obstruction, which for ready reference has been arranged in a systematic manner.

The advice given to the operator who is confronted by certain anatomico-pathological conditions is based upon clinical experience and the results of experimental investigation. It includes 138 pages in which the classification, frequency, the surgical resources in and the various forms of intestinal obstruction are carefully and clinically considered. There is also a brief chapter on the dynamic form of this lesion, caused by a suspension of peristalsis that may depend upon tympanites, peritonitis, catarrhal and ulcerative enteritis, or exenteration.

The second part represents the author's own original work, made with special reference to the surgical treatment of intestinal obstruction, and to the diagnosis of perforation of the gastro-intestinal canal; to which is added the report of three cases of gun-shot wound of the abdomen, in which the inflation of hydrogen gas proved a positive test in making a correct diagnosis before the abdomen was opened. The careful perusal of these pages will satisfy the reader that "experimental research constitutes the shortest and safest route to the perfection of the principles and practice of intestinal surgery."

There are incidental hints here and there that are very suggestive, of which we can only find space for the following: "In works on abdominal surgery we invariably meet with the assertion that serous surfaces brought into apposition by suturing unite after a few hours. Isolated experiments and the results of post-mortem examinations have given rise to the general belief that serous surfaces so united will become firmly adherent in a very short time; but the question concerning the exact time for adhesion to take place, and for the definite healing to be complete, can only be determined by experiments made for this special purpose. \* \* \* \* \*

It is quite important to make a distinction between the terms "adhesion" and "healing." Adhesion precedes the process of definitive healing, but implies simply the presence of an adhesion or cement substance between the serous surfaces, which mechanically agglutinates the parts; while definitive healing includes all the processes that take place during cicatrization. In intestinal surgery this distinction has an important practical bearing, as perforation may take place as long as the serous surfaces are simply held together by adhesions, while such an occurrence is beyond the reach of all possibilities after the approximated surfaces have become united by living organized tissue. Adhesions between serous surfaces take place by the exudation of plastic lymph, which acts the part of a cement material; while on the other hand, the process of definitive healing is initiated by cell-proliferation from the pre-existing endothelial and connective tissue cells, and the formation of a net-work of new blood vessels springing from each of the coaptated granulating surfaces. The processes are the same as we observe within blood vessels during cicatrization after ligature. In suturing an intestinal wound, or in making a circular enterorrhaphy, it has always heretofore been deemed necessary not to injure the peritoneum unnecessarily, for fear that such injuries would result deleteriously by interfering with the prompt union between the sutured surfaces.

THE TWELVE TISSUE REMEDIES OF SCHÜSSLER; COMPRISING THE THEORY, THERAPEUTICAL APPLICATION, MATERIA MEDICA, AND A COMPLETE REPERTORY OF THESE REMEDIES. Arranged and compiled by WM. BERICKE, M. D., etc., etc., and WILLIS A. DEWEY, M. D., etc., etc. Second edition, revised and en-

larged. Philadelphia; Hahnemann Publishing House. 1890; pp. 325.

The first edition of this book, which appeared only two years ago, elicited our warm approval. In its present revised form the volume contains all that made it valuable before, and whatever has been added to our general literature concerning these remedies since the date of that issue. Its bulk has not, however, been unnecessarily increased, for some of the old matter, which could be dispensed with, has been omitted and "fresh clinical illustrations by the best authorities," have been inserted.

The general title of the work is appropriate and comprehensive. Each of its four parts is a special monograph upon these remedies, and each and all of them will prove of real value to the physician. The more we have used them, even with the imperfect and insufficient data that have been in our possession hitherto, the more we have been impressed with their therapeutical scope and utility, in chronic cases especially. And whether the ingenious theory of their biochemical action, as advocated by Schüssler himself, is sufficient to account for their *modus operandi* matters little now that we have the key to their proper selection in individual cases.

Concerning the potencies of these tissue remedies that are usually employed, we read: "At first Schüssler began with the sixth centesimal or twelfth decimal trituration; but he, very early in his practice, adopted the sixth decimal as the one most generally useful. Lately the lower triturations of Potassium and Sodium salts the third decimal, of others the fourth and fifth, have been productive of equally good results. American physicians use all possible potencies, from the lowest trituration to the highest dilution."

Shüssler's original communication concerning these remedies was first introduced to the English-reading public by a Chicago Journal.\* If any one objects that nearly all of these tissue remedies are not simple but compound, it is easy enough to remind him of the child who wanted to know why she had two ears when she could hear only one thing at a time. If the book is not set for the defense of the faith, it is suited to the protection of our patients against the results of an overweening confidence in theory as opposed to clinical experience.

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\*The Medical Investigator, May, 1873.

## Miscellaneous Items.

The two items in everybody's mouth just now are the commencement of the old Hahnemann five days hence, and the location of the World's Fair in Chicago.—The Bureau of Surgery, Dr. G. F. Shears, Chairman, will report at the next meeting of the Clinical Society, March 29th.—Dr. H. C. Hoeffle, house surgeon at the Hahnemann Hospital two years ago, takes the practice of the late Dr. R. F. Baker, in Davenport, Ia.—Prof. Gee has taken Dr. H. C. Allen, formerly of Ann Arbor, into partnership.—The wife of Dr. A. S. Eshbaugh, of Lexington, Ill., died at Albuquerque, N. M., Feb. 14th, of pneumonia, following *la grippe*.—Ten thousand dollars of the legacy left the Hahnemann Hospital by the late Miss Phoebe Smith, of this city, has been paid into its treasury.—The final examinations in the College began March 10th. The Commencement exercises will be held as usual at the Chicago Opera House at 2 p. m., Thursday, March 20th, and the Rev. Dr. S. J. MacPherson will deliver the valedictory.—The Alumni Society will meet on the previous evening, at 8 o'clock, in the parlors of the Palmer House.—Prof. Hall has been ill but is now convalescent.—Dr. D. S. Smith has returned from Washington.—Prof. Vilas is visiting in Kentucky.—Prof. Ludlam removed a very remarkable dermoid cyst of the ovary at his clinic March 4th, and the patient is almost well again.—Dr. Alfred Heath, of London, who made a short visit to his friends in Chicago recently, sailed from New York March 8th.—The plans for the new hospital are out and the building will be ready for patients and students in September next.—The old trick of gargling the throat with a solution of muriatic acid is the best method of removing fish-bones.—A recent writer says, and very truly, that "the study of disease is well calculated to discourage dogmatism and to promote intellectual modesty."—Many of our old students and alumnae will regret to learn of the death of Dr. O. M. Baird, of which a fitting notice is given on the next page.—Dr. Frank C. Stewart, '86, late house physician to the hospital has recently made a pleasant visit to his old friends and his old quarters; and Dr. Homer P. Boyce, '89, is in town with a view to locating here.—Our next issue will contain a remarkable clinical lecture by Prof. Fellows.

IN MEMORIAM.

OSCAR MARION BAIRD, M. D., was born at Red Oak, Ohio, December 6th, 1861, and died at Chicago, Illinois, February 27th, 1890. At the time of his death he was Lecturer and Demonstrator of Anatomy in the Hahnemann Medical College and Hospital of Chicago. Failing in health for the past year, his college labors were carried on by others, and he sought a Southern climate in the hope of arresting the disease that threatened his life. Two weeks before death came to him, he returned to the city that he might once more be near the place he loved so well, and to die at his college home.

Dr. Baird was an exemplary young man. He graduated with the honors of his class in 1886, and at once began the practice of his profession at Champaign, Ill. He was married to Miss Clara J. Fleming but four months before his death. His ambition was boundless. Tasks seemed as trifles to him, and fatigue a weakness. He died from phthisis, induced by exposure and overwork. Like a hero of Italy, it may be said of him, "I had rather take one step forward and die than one ~~step~~ backward and live."

In social life he was genial and magnetic. He was a famous singer, and in his home a popular choir-leader in the church of which he was a consistent member. Since a lad of ten years he made his way in the world unaided save by his own exertions and determination.

In professional life he was most energetic and very soon acquired a large and remunerative practice. He was sympathetic, thorough and skillful. In his college work he commanded the respect of all, and inspired many a student with the love of thoroughness in study. His spiritual and moral nature prevailed every act of his life. It is the proudest legacy that he left. "Remember me," said he when dying, to his bride, "for the manly life I have already lived." The chains of disease that wrapped so tightly about him and kept him from the chosen work of his life

